CHAPTER 4

FREEDOM OF CHOICE

Once it is determined that a individual has needs that could likely be met either in an ICF/MR or in the community with the provision of waiver provided services, you must:

- inform the individual, or his/her legal guardian, of the feasible alternatives under the waiver,
- give the individual, or his/her legal guardian, a choice of institutional (ICF/MR) services or home and community-based (MR/RD Waiver) services, and
- inform the individual, or his/her legal guardian, of his/her right to request a fair hearing.

The **Freedom of Choice (MR/RD Form 1)** is used to document that you provided this information and gave the potential recipient the choice of services. Please note that the **Freedom of Choice (MR/RD Form 1)** does not have to be completed prior to the Level of Care; however, the **Freedom of Choice** form must be signed and "home and community-based services" chosen before the individual is enrolled in the Waiver. In most cases, the Level of Care date is the enrollment date except in noted exceptions. See Chapter 5 (*Level of Care*) for more information. Therefore, to meet compliance standards, the **Freedom of Choice** should be signed prior to completing the LOC. Also, please see Chapter 6 (*Enrollments*) for more information.

As stated, the **Freedom of Choice (MR/RD Form 1)** form must be signed and "home and community-based services" selected **prior** to waiver enrollment. The presence of this completed and signed form assures that you have explained the services available through the waiver and provided sufficient detail about both ICF/MR and waiver services for an informed choice to be made.

Additionally, a completed and signed **MR/RD Form 1 signifies** that you have informed the recipient of his/her right to request a fair hearing when he/she feels a choice of either institution or waiver services was not offered, he/she was not informed of feasible alternatives, was denied services of his/her choice, or was denied services from the provider of his/her choice. A "fair hearing" is conducted by an Administrative Law Judge who is employed by SCDHHS.

Two copies of the Freedom of Choice (MR/RD Form 1) should be prepared and when explained and a decision made, both copies signed. One copy should be placed in the individual's file. Since the decision remains in effect until the individual/legal guardian

changes his/her choice, this form will be a permanent part of the file and should not be removed or purged. The second signed copy of the form should be left with the individual/legal guardian.

Please note: if the initial Freedom of Choice form is signed by the parent or guardian of a minor, the form must be signed by the individual when he/she reaches the age of majority (age 18 in South Carolina) if he/she is not adjudicated incompetent. This may be done by completing a new FOC Form (MR/RD Form 1) or the individual can simply sign the current form. This should be done within thirty (30) days of the individual's eighteenth birthday.

After completing the **FOC Form (MR/RD Form 1)**, you should present the individual and/or his/her legal guardian with the **Acknowledgement of Rights and Responsibilities (MR/RD Form 2)**. You must carefully explain and review this information with the individual and/or his/her legal guardian and have the individual sign **the Acknowledgement of Rights and Responsibilities Form (MR/RD Form 2)** if they are over the age of 18 or the family member/legal guardian if the recipient is under 18 or cannot sign for himself or herself. You must also sign the form. This form **should be completed each year at the annual plan meeting.** Again, two copies should be prepared. One left with the consumer and/or legal guardian and the other copy will remain in the active file. For file maintenance, the current copy and the previous copy should be kept in the active file. Prior copies may be purged into the back-up file.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAIVER

FREEDOM OF CHOICE

Individual's Name: _____
Address: _____

_____

Phone #: _____
(Please type or print)

This is to certify that the above named individual was informed of the feasible alternatives under the waiver, given the opportunity to choose between institutional and home and community-based services and was informed of the right to request a fair hearing. The individual has selected by written acknowledgment, or by the written acknowledgment of his or her representative, to receive the option marked below.

Signature: _____ Date: _____
Service coordinator/early interventionist

Service coordinator/early interventionist's Name: _____
Address: _____
Phone #: _____
(Please type or print)

I, or my authorized representative, have been afforded an opportunity to make an informed choice of receiving either institutional or home and community-based services. My and/or my representative's signature below indicates that at this time, I have chosen to receive:

☐ **home and community-based services (MR/RD waiver)**
☐ **institutional services (ICF/MR)**

In the event that I have not been informed of feasible options under the waiver or been given the option of institutional or waiver services, I understand that I have the right to request a fair hearing.

Recipient's Signature: _____
Date: _____

Representative's Signature: _____
Date: _____

Representative's Name: _____

Representative's Address and Phone #, if different from Recipient's: _____

_____

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the CDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MENTAL RETARDATION/RELATED DISABILITIES (MR/RD) WAIVER

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

Name: _____

I acknowledge that this information is to assist me in understanding the Mental Retardation/Related Disabilities (MR/RD) Waiver Program, my rights, my responsibilities, and my benefits. I will keep this information in a place where I can find it. I can contact my Service Coordinator/Early Interventionist at _____ if I have any questions or need assistance.

I. By receiving services through the Mental Retardation/Related Disabilities (MR/RD) Waiver:

1. I have the right to be treated with dignity and respect by my Service Coordinator/Early Interventionist and all providers of my MR/RD Waiver services.

2. I have the right to confidentiality.

3. I have the right to receive a full explanation of all the forms that I am asked to sign.

4. I have the right to be told about all services available from SCDDSN.

5. I have the right to know the name of my Service Coordinator/Early Interventionist and how I can contact him or her during working hours.

6. I have the right to participate in the development of my single plan/IFSP/FSP, have my single plan/IFSP/FSP explained to me and a copy provided.

7. I have the right to choose the agency or provider for each of my MR/RD Waiver services from all qualified/enrolled providers (a list for each MR/RD Waiver service is available online at www.state.sc.us/ddsn/). My decision to receive services from a provider cannot be based on race, color, sex, religion or national origin.

8. I have the right to contact providers to evaluate service quality and gather information to assist in making an informed choice.

9. I have the right to change my provider by notifying my Service Coordinator/Early Interventionist.

10. I have the right to file an appeal if I disagree with any decision or action concerning my services or participation in the MR/RD Waiver.

11. I have the right to complain about waiver services/providers by contacting my Service Coordinator/Early Interventionist.

12. I have the right to discontinue participation in the MR/RD Waiver by contacting my Service Coordinator/Early Interventionist.

13. I have the right to be informed about any potential risk associated with waiver services. I have the right to assume that risk and be responsible for any consequences.

14. I have the right to refuse to participate in a MR/RD Waiver service, but understand that I must receive a MR/RD Waiver service at least every thirty (30) days. If I do not receive a MR/RD Waiver service at least every thirty (30) days, I will be terminated from the MR/RD Waiver with written notification and appeals information.

II. As a MR/RD Waiver participant:

1. I will treat my Service Coordinator/Early Interventionist and service providers in a considerate, respectful and courteous manner.

2. I will inform my Service Coordinator/Early Interventionist and all service providers in advance when I will be away from my home on dates of scheduled services/visits.

3. I will be present at the time of the provider's scheduled visits.

4. I will admit the service provider into my home.

5. I will not ask the service provider to perform tasks that are against the law or that are not a part of my single plan/IFSP/FSP.

6. I understand the MR/RD waiver will not provide for all of my service needs.

7. I will follow the agreed upon single plan/IFSP/FSP.

8. I will provide accurate and complete information about:
   - past and present medical histories;
   - my family or others who can provide supports;
   - other services being provided to me;
   - changes in my condition or situation, i.e. hospitalization, additional caregiver(s), income, and other events impacting my care;
   - changes in my address, phone number(s) and persons assisting me with my care; and
   - timekeeping records that I may be required to sign in regards to Personal Care, Respite or Companion services.

9. I understand that the MR/RD Waiver and DDSN do not provide emergency care. In case of medical emergency, I must contact my physician, go to the hospital or call 911.

10. I understand that I must be available for and participate in my annual plan meeting and that not participating may lead to the suspension of my waiver services.

I understand that not abiding by the rights and responsibilities indicated in this document may lead to the termination of wavier services.

_____ _____

Signature of MR/RD Waiver Participant (if age 18 years or older) — Date

OR

_____ _____

Signature of Parent/Legal Guardian (if MR/RD Waiver Participant is under 18 years of age) — Date

_____ _____

Signature of Service Coordinator/Early Interventionist — Date